Deputy Director
Social Work & Social Care Service
Adults and Health
Merrion House
Merrion Centre
LEEDS
LS2 8BB

[redacted]

Office of the Senior Coroner for the county of West Yorkshire (Eastern District)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

10 August 2021

Dear Sir/Madam,

Regulation 28: Report to prevent future deaths – Leeds City Council

I am writing in response to your letter dated 24 June 2021, and the enclosed Regulation 28 Report to Prevent Future Deaths regards the death of Ms. Netlyn Mae Robinson. I note that you made this representation following the inquest which concluded on 22 June 2021. We have reviewed your comments and have undertaken an internal review following receipt of this report and can confirm that Leeds City Council has taken immediate action on a number of the issues raised and has a clear plan in place to address those for which there is a longer timescale. Please see attached action plan.

The council takes this matter very seriously and is endeavoring to learn from the insights your report allows, following the sad death of Ms. Robinson.

[redacted]
Deputy Director – Social Work and Social Care Services

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Matter of concern raised by coroner	Action to be taken	Action to be taken by
1. In evidence it became apparent that there was no falls pendant or alarm provided on Mrs Robinson's return home despite her previously having one when last at home. There appeared to be no process in place to check whether there was a fully operational alarm system in place when needed. Further that Mrs Robinson was not consulted about the lack of an alarm until she arrived home thus no process in place to provide a person with relevant information in order that they are able to decide whether or not to return to their home address without any form of alarm. **2**. The telephone line was not connected. There appeared to be no process in place to check that telephones are working and that a vulnerable person	<u>Lessons Learnt Training Session (applies to points 1-6)</u> • The Mental Health Unit (MHU) to be provided with 'Lessons Learned' training session which will cover all points raised by the Regulation 28 Notice and mitigate risk of identified issues occurring in the future. • Training to include specific focus on telecare pendent alarms and other telecare services. This will include the need to consider referring for telecare at the start of the discharge planning process where the need for equipment is identified; making a note of existing equipment at the point of admission to residential care or hospital; checking that equipment is in place prior to discharge; testing of equipment on discharge; ensuring capacity and decision-making is recorded where a service user chooses to return home without recommended equipment in place and in working order. • Training to also include advising staff of other agreed actions (discharge checklist, Conversation Record pro-forma, Coroner's Court process/protocol) and implications for practice moving forward. <u>Discharge Checklist/Crib Sheet (applies to points 1,2,3,4,6)</u> • Task and finish group to be established to develop a discharge checklist/crib sheet to be used where a person is returning to a private residence following an extended stay in hospital or residential care. • Checklist will include the need for all utilities to be checked to establish they are in working order, prior to discharge where practicable, including that there is a working telephone line. • Checklist will include the need to consider referral to fire service where smoke alarms and CO detector are not in place or are not-working.	Training to be developed by Safeguarding and Risk Manager (SARM), Team Manager (TM) and Service Delivery Manager SDM) and delivered to all staff within the Mental Health Unit as a matter of priority prior to extending to wider social work teams. Discharge checklist/crib sheet to be developed by Task and Finish group. Group to be convened by Safeguarding and Risk Manager and to include Senior Social Worker representative from each team. Group to be chaired by Service Delivery Manager.

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has the ability to call for assistance (emergency or otherwise) or communicate with friends/relatives. **3**. With a lack of alarm or phone line there was still no risk assessment as to how an alarm could be raised. **4**. The heating was not working/turned on and again there appeared to be no process in place to check premises had heating, running water, or smoke alarms and therefore was not fit and safe for a vulnerable person to return to. **5**. The social worker stated he had been trained on the job to risk assess. He had never been shown a check list for the numerous issues that need to be checked prior to allowing a vulnerable person to be returned	• Checklist will include the need to consider environmental visit/assessment and referral for OT assessment where felt necessary. • Checklist will include recommendation that where indicated as required a social worker attends the property on the day of discharge, with service user's consent, where family/informal support are not able to assist. This intervention will include checking that utilities, smoke alarms and telecare equipment are working and that the service user is orientated to the property if they have been away from home for an extended period. <u>MHU Emergency Telephone (applies to point 1)</u> • The Mental Health Unit to purchase 'pay as you go' mobile phone which can be provided to service users on a temporary basis in the event home phone or personal mobile isn't working and/or where required telecare equipment isn't in place at the point of discharge. Provision of the emergency telephone will be considered as part of the risk assessment/care needs assessment processes already in place where discharge to private residence is being planned. <u>Conversation Record Pro-Forma Guidance Notes (applies to points 1,5,6)</u> • Task and finish group to be established to develop guidance notes for the Conversation Record pro-forma. This will be uploaded to the MHU Sharepoint site and MHU staff will be directed to consider using the pro-forma when undertaking assessments. There will be a particular focus on using the pro-forma for newly qualified social workers. • Pro-forma guidance to include need to record and consider medical diagnoses and any specific support/interventions required to manage health conditions.	MHU Emergency Phone to be purchased by SDM from MHU budget.

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home. This included checking on current medical needs (although Mrs Robinson did not have any reported issues regarding eating, chewing, swallowing, the question was not asked by the social worker ensuring her safe return home). **6**. It was acknowledged that the home was owned by Mrs Robinson, however, there appeared no process in place to outline what social services would and would not do to ensure that Mrs Robinson's premises were suitable.	• Pro-forma guidance to include need to consider equipment/telecare needs and consideration of referral to other professionals including Occupational Therapy or specialist health services such as SALT. • Pro-forma guidance to include undertaking a risk assessment as part of the wider assessment process. This will include highlighting identified risks, proposed risk management plans and service users' views on identified risks. This will also include the need to document where advice is given around risk management but declined by the service user. Where risk management/mitigation advice is declined, there will be a requirement that mental capacity around this decision is formally assessed and documented. <u>Coroner's Court Process/Protocol (applies to point 5)</u> • A process/protocol will be developed in consultation with LCC Legal to be used where social workers are required to give evidence at an Inquest. • The protocol will include the need for involvement from Team Manager/SDM when reviewing written statements to ensure they accurately reflect the work undertaken in a particular case. • The protocol will include a discussion with the social worker giving evidence around what to expect when attending the Inquest, the purpose of the Inquest and their role within the process as a witness. • The protocol will still apply where a social worker has left Leeds City Council and there will be an agreed expectation that their most recent Team Manager/SDM support the agreed process.	Conversation Record pro-forma guidance to be developed by Task and Finish group. Group to be convened by SARM and to include Senior Social Worker representative from each team. Group to be chaired by SDM with SARM deputising where required. SDM/SARM to liaise with LCC Legal representative to develop Coroner's Court Process/Protocol. Protocol to be communicated to all Team Managers once completed and training to be provided if necessary/required.

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